

## **Student Health Insurance Waiver Policy:**

(For Fall 2005 through Summer 2006)

OHSU mandatory student group health insurance policy makes possible a waiver under certain circumstances. A request to decline coverage from the University plan must show that the student's current insurance plan for which a waiver is sought meets the basic health coverage features of the university plan, i.e. to be approved it must be a plan open to all members of a group regardless of individual circumstances, including past medical history, race, ethnicity, gender, etc. And it must insure adequately against unanticipated medical costs at a minimum of half a million dollars lifetime benefit. Evidence of the following would meet these criteria:

- Employer group coverage with a minimum lifetime benefit of not less than \$500,000.00, where the insured is a spouse or a parent of the student, or the student's own employer group plan when the student is employed. (Employer group insurance is open to all in the group regardless of personal circumstances. Individual insurance requires a rating process of the individual before acceptance as a policyholder.)
- Coverage under Medicare, Medicaid, FHIAP, OMIP, or coverage under a Cobra plan that extends employer group coverage.
- A unique individual plan providing a minimum of \$500,000.00 lifetime benefit that meets extenuating circumstances such as the following: the student with a permanent ongoing medical condition who would not qualify for insurance for that condition after graduating and terminating the required OHSU student group insurance, is requesting a waiver to keep a plan which is guaranteed renewable permanently if not terminated, but would be irrevocably lost if terminated to enroll in the OHSU student plan.

These criteria are subject to change on an annual basis, and changes will be announced to new and continuing students in the month of May each year. **DEADLINES:** Beginning January 19, 2006, all applications for waivers must be received in the OHSU Student Health Service office *before* the first day of the month in which a student's program starts, or *before* the first day of the month in which fall term begins each year; must include a signed and notarized affidavit; and must be reapplied for annually at each fall term (the same deadline). Applications which do not include the required documentation as indicated on the waiver application form will not be considered. *Applications received on or after the first day of the month will, if approved, not be effective until the beginning of the next month.*

**Student Group Health Insurance Waiver Application and Affidavit**

*Deadline: Application must be received in the Student Health Service Office before the first day of the month in which your program starts if you are a new student; Or before the first day of the month in which the insurance is to be effective if you are a continuing student. Annual re-applications are due before the first day of the month in which fall term begins.*

Fall, Winter, Spring, Summer Terms 2005-2006

If Approved This Waiver Expires at the end of Summer Term, 2006

Student Name \_\_\_\_\_

SS#: \_\_\_\_\_

Email address of student to notify re: decision \_\_\_\_\_

Phone number: \_\_\_\_\_

Date of application: \_\_\_\_\_

OHSU degree or certificate program: \_\_\_\_\_

Campus you register on \_\_\_\_\_

Training start date: \_\_\_\_\_; expected graduation date: \_\_\_\_\_

Date received in Student Health Service: \_\_\_\_\_

**Major Medical Insurance—Required for All Students**

I hereby request to decline enrollment into the mandatory OHSU student group health insurance in favor of continuing my current alternative health insurance plan. If this waiver is approved, I certify that I will maintain this insurance and if it is terminated will notify OHSU in less than 30 days of such termination. I am requesting this waiver on the basis of one of the following three choices. (Check one):

- I. Employer group coverage with a minimum lifetime benefit of not less than \$500,000.00, where the insured is a spouse or a parent of the student, or the student’s own employer group plan when the student is employed.

**Required documentation:**

Name of insurance company: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

Group policy number: \_\_\_\_\_ ID# \_\_\_\_\_

Name of employer: \_\_\_\_\_

Name of primary insured: \_\_\_\_\_ DOB \_\_\_\_\_

Your relationship to primary insured: \_\_\_\_\_

Attach schedule of benefits showing lifetime maximum benefit of at least \$500,000.00.

Attach a copy of your insurance card.

- II. Coverage under Medicare, Medicaid, FHIAP, OMIP, or coverage under a Cobra plan that extends employer group coverage.

**Required documentation:**

If enrolled in a private insurance plan under one of the above programs, list the following:

Name of insurance company: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

Policy number: \_\_\_\_\_ ID# \_\_\_\_\_

Name of primary insured: \_\_\_\_\_ DOB \_\_\_\_\_

Attach proof of current eligibility and enrollment in one of above covered programs.

- III. Coverage under an individual health insurance plan providing a minimum of \$500,000.00 lifetime benefit where there are extenuating circumstances such as the following: the student with a permanent ongoing medical condition who would not qualify for insurance for that condition after graduating and terminating the required OHSU student group insurance, is requesting a waiver to keep a plan which is guaranteed renewable permanently if not terminated, but would be irrevocably lost if terminated to enroll in the OHSU student plan.

**Required documentation:**

Name of insurance company: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

Policy number: \_\_\_\_\_ ID# \_\_\_\_\_

Name of employer: \_\_\_\_\_

Name of primary insured: \_\_\_\_\_ DOB \_\_\_\_\_

Your relationship to primary insured: \_\_\_\_\_

Attach a *statement from insurance company* that current policy is guaranteed renewable on a permanent basis with no exceptions except non-payment of premium.

Attach *schedule of benefits* showing lifetime maximum benefit of at least \$500,000.00.

Attach narrative explanation of extenuating circumstance:

\_\_\_\_\_  
\_\_\_\_\_

**Dental Insurance – (Applicable only for Medical, Medical Graduate, MPH, Medical Informatics & PA students)**

*I hereby certify that I will maintain employer group dental insurance with the following company:*

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_ DOB \_\_\_\_\_

Group Policy # \_\_\_\_\_ ID# \_\_\_\_\_

**Vision Insurance – (Applicable only for Medical, Medical Graduate, MPH, Medical Informatics & PA students)**

*I hereby certify that I will maintain employer group vision insurance with the following company:*

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_ DOB \_\_\_\_\_

Group Policy # \_\_\_\_\_ ID# \_\_\_\_\_

I understand that this application and affidavit will not be considered without appropriate documentation, and that I am subject to sanctions up to and including permanent dismissal from the university for intentionally providing misinformation in this document.

I affirm that the statements in this affidavit are true to the best of my knowledge:

Dated:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip code

Sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Notary

If you lose this waived insurance at any time during the school year, you must (within 30 days) enroll in the OHSU student group plan or be approved for a new waiver for a different qualifying plan. Enrollment is allowed in the OHSU student group health plan during that 30 day period only for a qualifying event, such as marriage, birth or adoption, or termination of waived insurance (after expiration of any available Cobra benefit.)

**Address:** OHSU Student Health Service, Mail Code: L587  
3181 SW Sam Jackson Park Road, Portland, OR 97239  
**Phone:** (503) 494-8665      **FAX:** (503) 494-2958      **email:** askshs@ohsu.edu

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